

FILED JAN 13 1951

STANDARD CERTIFICATE OF DEATH
318State File No. 42183
11004

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 100		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 3 YRS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		2199	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4482 MARYLAND AVE				d. STREET ADDRESS (If rural, give location) 4482 MARYLAND AVE.			
3. NAME OF DECEASED (Type or Print) MARY		a. (First) E. b. (Middle) DOYLE		c. (Last) DOYLE		4. DATE OF DEATH (Month) (Day) (Year) DEC 24 1950	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH JAN 20 1859	
9. AGE (In years last birthday) 91		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		11. BIRTHPLACE (State or foreign country) PRINCE EDWARD ISLAND CANADA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME EDWARD McCARR		13b. MOTHER'S MAIDEN NAME MARY ASKIN		14. NAME OF HUSBAND OR WIFE MARTIN DOYLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME Mrs Etta Schneider 4482 MARYLAND AVE			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio-Sclerotic Hypertension Antecedent Causes Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cordis - Vascular Disease 2 y 1/2 DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Deformity 50 y				INTERVAL BETWEEN ONSET AND DEATH 50 y			
19a. DATE OF OPERATION NO		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) ALI		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200			
22. I hereby certify that I attended the deceased from Jan 1 - 1949 to Dec 24, 1950 that I last saw the deceased alive on 12-24-1950, and that death occurred at 1200 p.m., from the causes and on the date stated above.							
23a. SIGNATURE A. K. Kuehnert (Degree or title)		23b. ADDRESS 4340 W. Pine Ave		23c. DATE SIGNED 12-26-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE DEC. 27, 1950		24c. NAME OF CEMETERY OR CREMATORY CALVARY		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO.	
DATE REC'D BY LOCAL REG. DEC 26 1950		REGISTRAR'S SIGNATURE J. B. Renter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Cullen & Kelly 4386 LINDELL BLVD			

(Licensed Embalmers' Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____ Student Embalmer No. _____
working under my personal supervision.

Student
Student Embalmer

Signed

J Allen Davis Jr

Licensed Embalmer No. *4053*

P. O. Address *St Louis Mo*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.